Continuing the Conversation

#HCIntegration

eSolutions

eSolutions is a monthly e-newsletter from CIHS.

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- *Care Coordination*
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www.integration.SAMHSA.gov

Visit the CIHS website for resources to support Primary and Behavioral Health Care Integration

SAMHSA/HRSA Center for Integrated Health Solutions

The resources and information needed to successfully Integrate primary and behavioral health care

For information, resources and technical assistance contact the CIHS team at:

Online: integration.samhsa.gov
Phone: 202-684-7457
Email: Integration@thenationalcouncil.org

SAMHSA-HRSA Center for Integrated Health Solutions

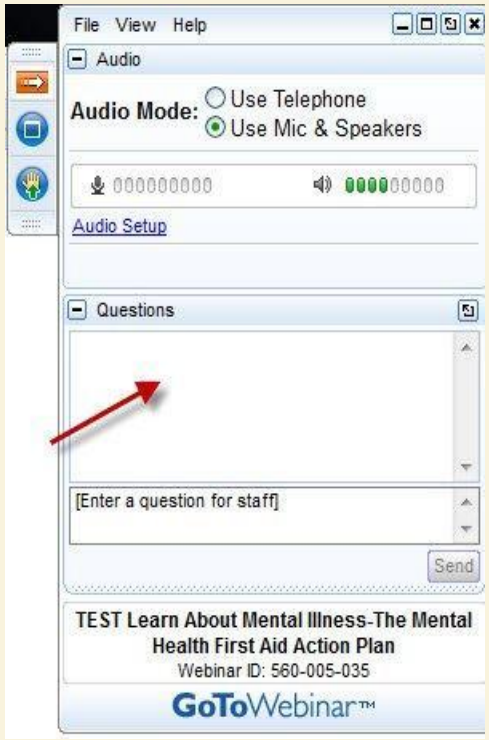
Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.

How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the "raise your hand" button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



Slides for today's webinar are posted on the CIHS website

www.integration.samhsa.gov/about-us/webinars

SAMHSA-HRSA
Center for Integrated Health Solutions

Integrated Behavioral Health in Migrant and Community Health Centers

Why Integrate?

Majority of visits to primary care offices have a mental health, behavioral, or psychosocial component

Mental health, behavioral, and psychosocial problems in primary care are under-recognized

Most people won't go to a mental health center

Why Integrate?

Traditional approaches to mental health aren't sufficient

Access to mental health professionals is difficult at best

- particularly for uninsured and underinsured populations

All problems are accentuated in vulnerable migratory populations

Integrated Care Goals

Triple Aim

- Improved quality
- Improved patient experience
- Reduced costs

Other Aims

- Improved provider recruitment and retention
- Enhanced primary care capacity
- Improved community health

Integrated Continuum

Referral model

- Mental health provider works elsewhere
- Could be across town or across the hall
- No meaningful sharing of infrastructure
- Communication generally by phone or letter

Integrated Continuum

Co-located ‘parallel play’ model

- Mental health provider works in same space, but with separate scheduling, charting, billing, etc

Integration Continuum

Co-located consultative model

- Mental health provider works in same space, using shared infrastructure
- Available to see patients at request of medical provider

Integration Continuum

Full integration model

- Mental health provider works in same space on same patients at same time
- All patients have access to services
- MHP does not wait to be invited into room by medical provider
- Care plan for every patient involves assessment by MHP

Requirements for Total Integration

Co-location

Universal screening

Real time access

Brief interventions

Solution focused therapy

'Cross training'

BHPs as primary care providers

Salud Family Health Centers

Salud Family Health Centers

Migrant/Community Health Center
9 full service sites plus a mobile unit
Expanded range of primary care services
Large dental program
~ 80,000 unduplicated patients annually
~ 300,000 annual visits
Integrated behavioral health since 1997

Salud's Integrated Mission Statement

"To deliver stratified, integrated, patient-centered, population-based services utilizing a diversified team of behavioral health professionals who function as PCPs, not ancillary staff, and who work shoulder-to-shoulder with the rest of the medical team in the same place, at the same time, with the same patients."

Integrated Behavioral Health Dept

16 FTE behavioral health providers

- Psychologists, Licensed Professional Counselors, LCSWs, MFTs

Part time psychiatrists

- Consultants to PCPs (not direct patient care)

Trainees

- Post-docs
- Interns
- Practicum students

Salud Integrated Care Model

Population based

- We want to reach EVERY patient

Real time interventions

- Most patients can see therapist today

Casts a wide net in determining need for psychosocial intervention

Exact interventions determined by patient need

Broad evaluative measures

Salud Integrated Care Model

BHP office in medical exam room space

BHP spends 70% of time doing screening, brief interventions, case management, etc

30% of time in more traditional therapy

- Solution focused
- Limited number of visits
- Referral as necessary

Frequent and ongoing consultations among docs and BHPs

Requirements for Total Integration

Co-location

Universal screening

Shared records

Real time access

Brief interventions

Solution focused therapy

'Cross training'

BHPs as primary care providers

How do patients gain access to BHP?

Screening

Direct appointment

Referral from provider

Patient request at medical visit

Other BHP Functions

Co-leaders of shared medical apptmts

- Centering pregnancy
- Chronic pain
- Diabetes, other chronic diseases

Mentoring Transitions of Care team

Staff education and training, for example in motivational interviewing

Liaison to Mental Health Centers

What Makes Our Program Different

Not a consultative model

Not focused on specialty level services

BHPs are primary care providers

Population-based

Not limited to depression

Goes far beyond ‘warm hand-off’

Resistance

From BHPs

- I can't just walk in on a patient
- I like to spend more time with patients
- I like to get deep into my patients' psyche
- I don't like all the interruptions
- This isn't the way I was trained

Resistance

From medical providers

- I'm the captain of the ship
- I don't like other people seeing my patients
- The BHP slows me down
- I'm really good at psych stuff and I don't need help
- This isn't the way I was trained

What do patients think?

NO resistance

Accepted part of total care package at Salud

Seen as value added service

Why do we need to integrate behavioral health into the healthcare home?

Primary Care

Primary care is the provision of INTEGRATED, ACCESSIBLE health care services by clinicians who are ACCOUNTABLE for addressing a LARGE MAJORITY of personal health care needs, developing a SUSTAINED PARTNERSHIP with patients, and practicing IN THE CONTEXT OF FAMILY AND COMMUNITY.

Screening at Salud

Depression	31%
Anxiety	25%
Alcohol	6%
SA	4%
Tobacco	25%
PTSD	9%
ANY CONDITION	47%

"…LARGE MAJORITY of personal healthcare needs…":

Can we be considered primary healthcare homes if we don't take care of behavioral health issues?

Funding

Funding Models

Widgets – Fee for service

- PCPs can't bill for mental health diagnoses under carve-out system
- Mental health services and medical services can't be billed on same day
- Not all states have activated the Health Behavior codes
- Only certain licenses valid for billing
- We can't bill for services which patient did not request
- People shouldn't be treated like widgets

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http://www.integration.samhsa.gov/

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Technical Assistance

Have a question about primary and behavioral health care integration?
Contact the CIHS team for information, resources, and individualized technical assistance.
integration@thenationalcouncil.org

202.684.7457

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Webinars

Preparing for Bidirectional Integration: Lessons from the Field
2012-06-14
• Recording • Presentation

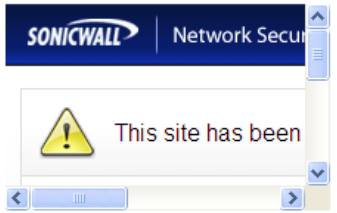
Billing for Integrated Health Services
2012-06-12
• Recording • Presentation

Behavioral Health Homes: The Core Clinical Features
2012-05-30
• Recording • Presentation

Integration Models: Lessons From the Behavioral Health Field
2012-05-23
• Recording • Presentation

Treatment of Chronic Pain: Our Approach
2012-03-06
• Recording • Presentation

Videos



Welcome to CIHS
2011-10-18

Laura Galbreath, deputy director of the SAMHSA-HRSA Center for Integrated Health Solutions, provides an overview of CIHS.

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Funding Models

Mental Health as Cost Center

- Build mental health services into budget
- Mental health services allow medical providers to be more productive
- How many more patients do I need to see to pay for a mental health provider?
- 3 docs working 180 days per year: 1 extra patient per day will pay for a MHP
- Variation on the widget model

MHP:Medical Provider Ratio 1:4

4 providers
x 180 days/year
x $80 avg revenue
x 1 extra patient per day

$57,600

Funding Models

Managed care model

- Part of PMPM can go to mental health services

Pay for Performance model

- Integrated care has better outcomes

Internship program

- Low cost PhDs
- Need to pay for supervision (~$100-150/week)
- Personnel will change every year

Funding Models

Collaborate!

- Work with local mental health centers and others to place mental health providers within health center
- Develop shared plan for integration
- Set up ground rules and expectations from beginning

Salud Integrated Care Funding Models

Mental Health Expansion grant from HRSA

Partnership with local health district

Partnership with local mental health centers

Mental health as cost center – commitment of general operating funds

Grants from private foundations

Allocation of PMPM revenue

Training programs – post-docs, interns, students, etc

Caveats

Requires functional and efficient teams

Costs are incurred and savings are accrued in different places

This is a primary care model – we still need specialist mental health providers

Be careful of evaluation – paperwork is not healthcare